CITY OF MESA HEALTH PLAN
Retiree Open Enrollment Workbook
2013 Summary of Benefits

2013 Open Enrollment starts October 22 and ends November 2, 2012 at 6p.m.

Open Enrollment changes are effective January 1, 2013

WHAT'S INSIDE

Contents

The information in this workbook provides general information on programs and summaries of health benefits offered to City of Mesa members. All information is subject to change and is not a guarantee of benefits.

What's New For 2013

The following changes are effective January 1, 2013

Descriptions of these changes are found in the Enrollment Workbook

Prescription Drug Provider under the Medical Plans

On January 1, 2013, the City will have a new prescription drug provider, CVS Caremark. You will have ready access to quality pharmacy care at over 66,000 in-network locations (all major pharmacy chains, most independents), including the provider's own extensive network of 7,300 CVS retail pharmacies nationwide.

CVS Caremark has an enhanced 90-day supply, "mail order" delivery program. You can choose whether to receive your 90-day supply of medications in the mail at your home address from CVS Caremark mail order pharmacies or purchase and pick-up your 90-day supply of **both Brand Name and Generic medications from CVS Caremark retail pharmacies, at mail order prices**. You will have year round flexibility to make your own choice: convenient mail delivery at home or purchase/pick-up at CVS Caremark retail locations.

City of Mesa prescription drug program participants will also receive a CVS Caremark Extra Care Health Card that gives 20% off CVS/pharmacy Brand health-related products valued at $1 or more. This discount card cannot be used for prescription drug purchases but can be used for over-the-counter CVS Brand products like cough and cold remedies, pain relief, first aid, vitamins, skin care, baby care and many more health care items you and your family use every day.

These programs are examples of the quality and service features you will enjoy under your City of Mesa prescription drug benefit program in 2013. Medical ID cards with your new Prescription Drug ID information (CVS Caremark) will be sent to your mailing address in late December. Remember to present your new card to your retail pharmacy the first time you fill a prescription in 2013, so that your prescription drug provider information and your benefit coverage information can be updated. There are no other changes in prescription drug copays, coinsurance or deductibles for 2013.

Premiums

There will not be any changes to the medical, dental or vision premiums you pay to be covered in City of Mesa Retiree plans in 2013. Your rates remain the same as in 2012 for the same plan/tier of coverage, and taking into account whether or not you and/or your covered dependents are Medicare eligible. If you need information about your 2013 rates you can refer to your 2012 letter that you received last October, or you can contact Employee Benefits at (480) 644-2299.

Network for Retirees/Dependents Living Out-of-State of Arizona

If you or your dependents reside all or most of the year outside Arizona, and you are enrolled in an out-of-state (OOS) BCBS Medical plan option, you can continue to use the Blue Cross Blue Shield network of providers and claims administration. If you or your dependent(s) are already enrolled in an OOS plan with no change to the state in which you are resident for most of the year, you do not have to do anything in the online Open Enrollment process.

If you want to move from an Arizona based plan to an OOS BCBS plan as of January 1, 2013, or if you want to move from a current OOS BCBS plan to another state OOS BCBS plan, you must submit an Enrollment Form (available on www.mesaaz.gov/benefits) with documentation of your new out-of-state address. If you want to add a new dependent to your coverage in an OOS BCBS plan, you must add them to your plan option in the online Open Enrollment process (see next section) and submit an Enrollment Form (available on www.mesaaz.gov/benefits) with documentation of the dependent's out-of-state address and relationship to you.

In the above examples, the required Enrollment Form and related verification documentation must be received by the Employee Benefits Office **by close of business at 6:00 p.m. on Wednesday, November 7, 2012.**

There is no additional charge for retirees/dependents to enroll in the out-of-state network plan, but any out-of-state retiree or dependent who is not enrolled will only be covered under the out-of-network benefit provisions of the applicable Arizona based plan option. You will be responsible for the out-of-network deductible and co-insurance. *Note: out-of-network co-insurance does not apply to emergency care in a life or limb threatening situation.*

Adding New Dependents in Open Enrollment

If you add dependent(s) during Open Enrollment, you must provide their social security number in the enrollment process and submit a copy of documentation that verifies their relationship to you, no later than November 7, 2012. For example this documentation could include:

- *Spouse – marriage certificate*
- *Child – birth certificate with your name as parent or adoption, foster, or legal custody placement papers*
- *Stepchild – birth certificate for child, natural parent's divorce decree and marriage certificate proving your marriage to child's parent.*

If the documentation is not received by the Employee Benefits Department on or before November 7, 2012 your dependent cannot be added until next Open Enrollment or a later qualifying family status/special enrollment change.

Social Security Number Requirement

To comply with federal law, social security numbers for employees, retirees, spouse, children and other eligible dependents ***must*** be entered in the online Open Enrollment system to complete enrollment. Be sure to have these social security numbers available to you before you start the online Open Enrollment process.

Changes to the 2013 Plan Document

- The Choice Plus PPO plan will no longer be offered for new enrollments in 2013. Any employee/retiree currently enrolled in the plan on or before 12/31/12 can remain in the plan, but no new enrollments will be permitted.
- Medical plans offered to all eligible employees and retirees in 2013 include: Choice PPO (80/20), Basic Choice PPO (50/50) and Copay Choice PPO.
- CVS Caremark is the new Prescription Drug provider under the Medical Plans in 2013.
- Due to Health Care Reform regulations there are some enhancements to Preventive Care for Women that allow for 100% coverage on certain Generic contraceptive drugs and other family planning devices and related services (in-network).

Retiree Benefit Premium Payment Cycles in 2013

The City will move from a "month in advance" retiree invoicing and Surepay deduction cycle for health plan premium payments. Instead, the process will change to a "concurrent month" billing/deduction cycle in 2013. This means that you will receive an invoice at the end of each month or very early the next month (starting in late December, 2012 or early January, 2013) for a due date of the 15th of the month, to pay your premiums for **the month of coverage that includes the 15th of the month showing on the invoice**. Surepay deductions that you authorize and schedule will occur on or about the 10th of each month, again for that month's coverage payment. In order to transition to a "concurrent month" invoicing and payment cycle for 2013, you will see the following billing cycle processes during the next several months:

Invoice Date	Due Date	Month of Coverage/Payment
10/1/12 or 10/3/12	10/15/12	November, 2012
Approximately 11/1/12	11/15/12	December, 2012
No invoice 12/1/12	None	Not applicable (Transition month)
Approximately 1/1/13	1/15/13	January, 2013
Approximately 2/1/13	2/15/13	February, 2013

As always, you are still welcome to pay your premiums as far in advance as **you** prefer, and we greatly appreciate your willingness to do that when your monthly premium amount is less than $10.

All benefits described in this Enrollment Workbook are for general information only. The Plan Document describes in detail the benefits covered under the plan.

Online Open Enrollment

Online Open Enrollment begins October 22 and ends on November 2, 2012 at 6:00 pm.

Who needs to participate in online Open Enrollment?

- **Retirees** who wish to make changes to their health plan elections, add or delete dependents.
- **EVERYONE** who wants to participate in our satisfaction survey (See below for more information).

If you do not want to make any changes for 2013, you do not have to go online in the Open Enrollment system this year! You will remain in the same benefit coverage you have now. If you do not make any changes to benefit selections during this Open Enrollment period or within 31 days of a qualifying event for a Special Enrollment later on, you must wait until the next Open Enrollment to enroll or make changes.

Special note: a retiree medical, dental or vision coverage drop is irrevocable after the end of the Open Enrollment period. You do not have the option to re-enroll as a retiree.

Remember, if you go into the online Open Enrollment system and make any benefit plan changes, additions or deletions, you must **complete the "check out" step** for any of these actions to take effect. If you forget this step and log out, the system will default to your current coverage.

Step-by-Step Online Open Enrollment Instructions

IMPORTANT!!! READ THIS BEFORE YOU BEGIN THE ONLINE PROCESS

1. Access the Internet, and type www.mesaaz.gov/benefits into the web browser window.

2. Click on the "OPEN ENROLLMENT ENTER HERE" button to access the Open Enrollment System. Do ***not*** click on "Member Login."

3. In the Insured ID field, type your 5-digit ID number found on your health insurance card. If you don't know what your Insured ID number is, contact the Benefits Office at 480-644-2299.

4. In the Password field, type the following **Initial Password** scheme: The first four letters of your last name* (in upper or lower case) plus the last four digits of your Social Security Number (SSN).

*If your last name contains:	Last Name Example	Your SSN is:	Your password is:
Four or more letters	JONES	987654321	JONE4321
Two or three letters	COX	987634321	COX4321
More than one name	DE LA TORRE	987654321	DE L4321 (System reads space as a character)
An apostrophe	O'MEARA	987654321	OMEA4321 (System does not read apostrophes)
A hyphen after the first 3 letters	DEL-MONTE	987654321	DEL 4321 (Substitute a space for the hyphen)

You have five chances to enter your Insured ID and Password correctly. **After the fifth try, you will be locked out of the system.** After 10 minutes, you can attempt to login again.

5. On the next screen, follow these steps:
   a. Enter your 5-digit Insured ID (see above).
   b. Re-enter the Initial Password scheme (see Step 4)
   c. In the next box, create an entirely new password of at least six letters and numbers.
   d. Re-enter the New Password.
   e. Click the "Save Password" button.

Make a note of your new Password. You will need it to go in and out of the Open Enrollment system. **NOTE: This password is for the Open Enrollment system *only*; *it is not* your mesaaz.gov/benefits login.**

6. Carefully follow the instructions for each portion of the Open Enrollment system.

7. You **MUST** complete the "check out" process and click the final "check out" button for any changes to be effective. Print a copy of your confirmation for your records. **Please review your confirmation sheet to make sure you have enrolled correctly.**

8. Sign out when your session is complete.

Need assistance? Review "Helpful Hints for Online Enrollment" on the next page, or call the Benefits Office at 480-644-2299. On Friday November 2, phones will be answered from 7:00 a.m. to 6:00 p.m., although the office will be closed to walk-in traffic.

Helpful Hints for Online Enrollment

1. Use the Action Checklist later in this Workbook as you review the Open Enrollment/Benefits Package to mark your coverage selections before you begin the Online Enrollment process.

2. Can't get into the Open Enrollment system? Did you click on the blue button labeled, "OPEN ENROLLMENT ENTER HERE"? If you clicked on "Member Login," you are not in the right area. The Member Login is different from the Open Enrollment System Login.

3. Member ID not being accepted? Did you type in 4 digits instead of 5? The old 4-digit IDs require a leading zero. For example, if your employee ID is 1001, enter it as 01001.

4. If you enter the system for a second time, remember that you changed your password after you entered the initial password scheme. The new password is a combination of letters and numbers, at least six characters long. If you can't remember what you changed your password to, use the "Change Password" link on the first screen of the Open Enrollment system.

5. Carefully follow the instructions on each portion of the Online Enrollment screens.

6. For your convenience, if you are not making any changes to your benefits you may click the "Flexible Spending Amount = 0" button, and all your elections will remain the same as this year. Click on the "Final Checkout" button and print your confirmation.

7. At any time you may click on any selection and make changes, even when the status shows "Completed". Just be sure to save any changes and go to "Final Checkout" and print your confirmation.

8. If you have any dependents you wish to add or delete, you will need to complete the Dependent selection.

9. Going from single coverage to family coverage? Be sure to click on Family Coverage for each plan (medical, dental, vision) you wish to switch to family coverage. Also be sure to add your dependents.

10. Remember to submit any verification paperwork to the Employee Benefits Office no later than 6 pm on Wednesday, November 7, 2012. Failure to comply with this requirement may result in a change in your elected coverage.

11. If you have questions on any of these tips or if you are still experiencing problems with your online enrollment, please contact the Benefits Office at 480-644-2299, Option 2 during business hours, Mon - Thurs, 7:00 a.m. to 6:00 p.m. The Benefits Office will also answer calls on Friday, November 2, 2012 but no walk-in traffic will be permitted.

CHANGING ENROLLMENTS IN BENEFIT PLANS

Enrolling Dependents for the First Time
Members who enroll in family coverage and whose eligible dependents have never been enrolled in one of the City-sponsored plans before MUST submit copies of the following documents, as applicable, to the Employee Benefits Office BEFORE coverage begins:

- Marriage Certificate, if enrolling a spouse or stepchildren
- Birth Certificates, adoption documents or other court documentation verifying legal guardianship, if enrolling one or more children
- Natural parent's divorce decree (if applicable) and the stepchild(ren)'s birth certificate(s) if enrolling one or more stepchildren
- Proof of insurance if you or your dependents are covered under another health insurance plan including Medicare

Who Are My Eligible Dependents?

- Legal spouse
- Natural children and stepchildren under age 26
- Legally adopted children, foster children, or children for whom you/your spouse are a court-appointed guardian under age 26

When Can I Add or Drop a Dependent?

- Benefit elections can only be changed during the year (Special Enrollment) if there is a Qualified Status Change
- Employee Benefits must be contacted within 31 days of the event or the change must wait until the next Open Enrollment

Changes in status include:

- Marriage
- Divorce
- Birth, adoption or legal custody of a child
- Dependent no longer eligible under the plan due to age
- Death of dependent (spouse or child)
- Spouse loses or gains coverage eligibility due to change in employment
- Spouse's open enrollment period

IMPORTANT NOTICE REGARDING ONLINE ENROLLMENT

If you have or anticipate a status change (i.e., newborn, marriage, divorce, or adoption) that becomes effective in October, November or December 2012, please contact the Employee Benefits Office **before** your online Open Enrollment. For example, if you are getting married on October 22, contact us at 480-644-2299 before adding your new spouse online.

<u>REMINDER</u> Retirees and their dependents are required to enroll in Medicare Part A and Part B when eligible, at age 65 or earlier if eligible due to disability. Failure to enroll in Medicare will result in termination of City of Mesa health insurance coverage without option to re-enroll. Please provide the Employee Benefits Office with a copy of the Medicare card.

ACTION CHECKLIST

Complete this checklist before accessing the online open enrollment system.

COVERAGE OPTIONS – Check the level of coverage you want to enroll in

MEDICAL PLAN OPTIONS

Choice PPO – 80/20 Plan

☐ Member Only (Single Coverage)
☐ Member and Family (Family Coverage)

Copay Choice – Copay for most services

☐ Member Only (Single Coverage)
☐ Member and Family (Family Coverage)

Choice Plus PPO – 90/10 Plan *No new enrollments in 2013 – must be in plan in 2012 to continue this coverage*

☐ Member Only (Single Coverage)
☐ Member and Family (Family Coverage)

Basic Choice PPO – 50/50 Plan

☐ Member Only (Single Coverage)
☐ Member and Family (Family Coverage)

☐ **Opt Out** –If you opt out of medical coverage as a retiree, you are no longer eligible for medical benefits in the future.

DENTAL PLAN OPTIONS

Preventative Choice – 80/20 Plan, $500 annual max., no orthodontia or other major services

☐ Member Only (Single Coverage)
☐ Member and Family (Family Coverage)

Dental Choice – 80/20 Plan, $1200 annual max., no orthodontia

☐ Member Only (Single Coverage)
☐ Member and Family (Family Coverage)

Dental Choice Plus – 80/20 Plan, $1500 annual max., orthodontia for children under age 19

☐ Member Only (Single Coverage)
☐ Member and Family (Family Coverage)

☐ **Opt Out** – If you opt out of dental coverage as a retiree, you are no longer eligible for dental benefits in the future.

VISION PLAN OPTIONS

Basic Vision – annual exam, glasses/contacts every 24 months

☐ Member Only (Single Coverage)
☐ Member and Family (Family Coverage)

Vision Plus - annual exam, glasses/contacts every 12 months

☐ Member Only (Single Coverage)
☐ Member and Family (Family Coverage

☐ **Opt Out** –If you opt out of vision coverage as a retiree, you are no longer eligible for vision benefits in the future.

DEPENDENT INFORMATION

☐ **Spouse Name** _____date of birth _____

☐ Spouse social security number (required)_____

☐ **Child Name** _____date of birth _____

☐ Child social security number (required)_____

☐ **Child Name** _____date of birth _____

☐ Child social security number (required)_____

DOCUMENTATION REQUIRED FOR NEW DEPENDENTS OR A CHANGE IN STATUS

☐ **Add Spouse** – marriage certificate
☐ **Add child** – birth certificate; foster, adoption, or legal custody papers
☐ **Add stepchild** – birth certificate, natural parent's divorce decree, retiree's marriage certificate
☐ **Delete spouse** due to divorce – copy of divorce decree (you must delete spouse if divorced)
☐ **Delete stepchildren** due to divorce - copy of divorce decree (you must delete stepchildren if divorced)
☐ **Proof of insurance/**insurance card for dependents covered under another health insurance plan

NOTE: If you have or anticipate a status change (e.g., newborn, marriage, divorce, or adoption) that becomes effective in October, November or December 2012, please contact Employee Benefits at (480) 644-2299 ***before*** *doing your online Open Enrollment.*

City of Mesa Health Plan Highlights 2013

	CHOICE PPO PLAN 80/20		CHOICE PLUS PPO PLAN 90/10 (No new enrollments)		BASIC CHOICE PLAN 50/50		COPAY CHOICE	
Medical Services	**In-Network Providers**	**Out-of-Network***	**In-Network Providers**	**Out-of-Network***	**In-Network Providers**	**Out-of-Network***	**In-Network Providers**	**Out-of-Network***
Deductible per calendar year	$300 per person; $900 per family	$1000 per person; $3000 per family	$200 per person; $600 per family	$1000 per person; $3000 per family	$550 per person; $1650 per family	$1000 per person; $3000 per family	None	$1000 per person; $3000 per family
Hospital Services	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	After deductible, 50%	After deductible, 25%	$100 copay OP; $200 copay IP	After deductible, 60%
Physician & Health Care Practitioner Services	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	$20 copay for OV, all other services 50% after deductible	After deductible, 25%	$20 copay	After deductible, 60%
Chiropractic visits – 25/calendar year	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	After deductible, 50%	After deductible, 25%	$20 copay	After deductible, 60%
Rehabilitation Services	Rehabilitation Services include physical therapy, occupational therapy and speech therapy as defined in and covered under the plan							
	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	After deductible, 50%	After deductible, 25%	$20 copay	After deductible, 60%
X-Ray, Diagnostic	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	After deductible, 50%	After deductible, 25%	No deductible, 100%	After deductible, 60%
Emergency Room	After deductible, 80%	After deductible, 80%	After deductible, 90%	After deductible, 90%	After deductible, 50%	After deductible, 50%	$100 copay, ($200 copay if admitted)	$100 copay, ($200 copay if admitted)
Urgent Care Facility	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	After deductible, 50%	After deductible, 25%	$50 copay	After deductible, 60%
Durable Medical Equipment (DME)	Includes durable medical equipment rentals and purchases as defined in and covered under the plan							
	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	After deductible, 50%	After deductible, 25%	$20 copay	After deductible, 60%
Preventive Care, Immunizations	***In network*** preventive immunizations and other services are payable at 100%, no deductible, copay, coinsurance, or maximum. See plan document for details.							
	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered
Behavioral/ Mental Health Office Visits	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	$20 copay	After deductible, 25%	$20 copay	After deductible, 60%
Alternative Health Care (Acupuncturists Naturopaths, Homeopaths) office visits	After deductible, 80% up to $1,000/year	After deductible, 60% up to $1,000/year	After deductible, 90% with no annual max	After deductible, 70% with no annual max	Not Covered	Not Covered	Not Covered	Not Covered
Out of Pocket Maximum	$2,000 per person	None	$1,000 per person	None	$5,000 per person	None	None	None

This chart is a **summary** of how eligible services will be covered. For a complete list of services and more detailed information, please refer to the City of Mesa Health Plan Document available at www.mesaaz.gov/benefits or from Employee Benefits.
*Allowable costs will be applied to out-of-network services in addition to the deductibles and co-insurance specified.

Precertification & Case Management

Arizona Foundation for Medical Care

Precertification

- Required under all City of Mesa Medical Plans for certain covered services
- Ensures that hospitalizations, surgeries, and other procedures are medically necessary
- The physician's office will contact the plan on your behalf to pre-certify required services
- **Members are responsible for making sure services have been pre-certified. Services that are not pre-certified will not be covered.**

A list of services that require authorization can be viewed in the plan document and may not be inclusive of all services requiring precertification, services are considered for coverage subject to medical necessity.

Some procedures that require precertification:

- All elective non-emergency admissions, except for birth of a baby (not including post-natal)
- All elective admissions to specialized facilities, including outpatient surgical centers, hospice, skilled nursing facilities, and sub-acute care facilities
- All admissions to inpatient or day treatment rehab facilities for both medical and mental health services
- Colonoscopies, except those covered under the preventive care benefit
- Other invasive and noninvasive diagnostic tests including MRI
- Sleep studies
- Durable Medical Equipment with a cost of $1000 or more;

Utilization (or Concurrent) Review/Case Management – Arizona Foundation for Medical Care

- Ensures that services and treatment are medically necessary
- Coordinates member care with other health care providers, such as home health agencies, durable medical equipment vendors, and others
- May also assist with discharge planning and advising medical providers of various options available under the plan

Non-Covered Services

Services that are not covered under the City of Mesa Medical Plans include, but are not limited to:

- Cosmetic surgery or related expenses
- Fertility treatment, except limited services available under the Choice Plus PPO Plan
- Health club memberships
- Massage therapy, except when performed by a physical therapist, chiropractor, or medical doctor
- Medications not approved by the FDA
- Nutritional supplements and/or vitamins (except certain prenatal vitamins)
- Services that are experimental and/or investigational in nature
- Vision services, except exams and lenses required following cataract surgery (vision services are covered under a separate optional plan)
- Weight management programs.

For more detailed information about services that are not covered, please contact Employee Benefits at (480) 644-2299 or refer to the Plan Document.

Other Insurance Coverage

- Member and dependents who are covered by another health insurance policy must submit a copy of the insurance card from the other carrier or other documentation to the Employee Benefits Office
- If other coverage has been terminated, documentation of the termination date must be submitted
- Certain rules determine which plan is primary (i.e., which plan pays first)
- The City of Mesa plan does not coordinate benefits with primary plans that have co-pays.
- For assistance with determining which of your insurance carriers is primary, please contact Employee Benefits at (480) 644-2299.

Medical Coverage for Out-of-State Members

Blue Cross Blue Shield is the out-of-state network for those City of Mesa health plan members who live outside the state of Arizona. BCBS allows eligible members to use their providers throughout the United States, including hospitals, urgent care centers, doctors and specialists. The network is only for those covered persons who regularly live outside Arizona. ***It is not for members who reside in Arizona who are traveling outside the state.***

The Benefits Office must be notified if a member or an eligible dependent is moving out-of-state, or will be residing outside the state for four months or more of the year. Members who do not enroll in the BCBS out-of-state network will have all non-life or limb-threatening services covered at the out-of-state network benefit, including routine and urgent care, scheduled surgeries, etc. Life or limb-threatening services will be reviewed to determine if emergency care was medically necessary.

There is no additional charge to enroll in the out-of-state network plan. Out-of-state dependents not enrolled will only be covered under the out-of-network benefit. For out-of-state members who use a BCBS contracted provider, services will be processed as in-network for the plan selected. For example, if a member is enrolled in the Choice 80/20 plan, services rendered by a BCBS provider will first be subject to a $300 per person annual deductible, and then paid at 80%. If a non-network provider is used by a Choice member, or if the member is not enrolled in the BCBS out-of-state plan, services will be processed as out-of-network (subject to a $1,000 deductible, then paid at 60% or 25% depending upon the plan).

Your provider will need to pre-certify services outlined in the plan document with the Arizona Foundation for Medical Care, the City's medical management company.

If the City of Mesa is your primary or only carrier, present your BCBS card to the provider at the time of your appointment. If you did not receive a card, contact BCBS at (866) 288-5788. Give your provider the member number on your BCBS out-of-state network ID card as the Insured ID-number. **If the City of Mesa is your secondary carrier** (for example, if you are on Medicare), inform the provider that you have primary insurance. The itemized bill with the primary carrier's Explanation of Benefits should be sent to BCBS. ***Claims should not be sent to the City of Mesa Employee Benefits,*** as that will delay payment. Members and providers should call BCBS, not the City of Mesa, with questions or to verify coverage.

To Find an Out-of-State BCBS Provider, call Blue Cross Blue Shield at (866) 288-5788 and state your member ID number and group number as it is printed on your card. You can also log in to Blue Cross Blue Shield's web site to do a provider search:

- Visit the provider directory at azblue.com
- Choose the tab for "Outside of Arizona Directories"
- Click the link for "Search the BlueCard U.S. Directory"
- At the prompt, enter the alpha prefix MDK (custom alpha prefix for City of Mesa)
- Enter desired criteria to begin the search

Prescription Drug Benefit Highlights 2013

Prescription drug benefits are available through City of Mesa Medical plan options using the new CVS Caremark provider network. For locations of network pharmacies or information on covered drugs and formularies, contact CVS Caremark at 855-264-3455 or visit www.caremark.com (beginning January 1, 2013).

Generic Drugs

If a Generic drug is available and the member or physician refuses substitution to the Generic:

- The member will pay the appropriate Brand Name percentage or copay PLUS
- The difference in cost between the Generic and Brand Name drug

Mail Order Program

Under CVS Caremark you can chose to receive your mail order supplies of Brand Name and Generic medications (up to 90-day supply) from the Mail Order pharmacy or directly from a CVS Caremark Retail pharmacy, all at "mail order" prices (copays and/or co-insurance).

Prescription Drugs Covered Under this Plan

- Most drugs, including injectable and specialty medications, are covered. Members who have questions about whether specific drugs are covered should contact CVS Caremark
- Some drugs require Prior Authorization (PA). Contact CVS Caremark to determine PA classifications and procedures.
- To obtain the best discounts and keep your out of pocket costs as low as possible, stay in-network especially for injectable and specialty medications, through CVS Caremark Specialty Pharmacy.

Generic Medications for $4/$10

- Many retail pharmacies offer 30-day supplies of Generic drugs for $4 and 90-day supplies for $10 - these pharmacies include **Wal-Mart, Target, Fry's and Basha's.**
- Take advantage of these low-cost Generic prescriptions whenever possible. You may find that the "list" of $4/$10 Generics is different from one supermarket pharmacy chain to another (and subject to change over time), so check around before deciding where to purchase.
- Even though these supermarket chain pharmacies may also be in the CVS Caremark network of pharmacies, the cost of these discounted $4/$10 prescriptions **IS NOT** reimbursable through the City of Mesa Employee Benefit Trust Fund, so using them will not only save you money but will save the Fund money as well.

For detailed information on prescription drug coverage refer to the City of Mesa Plan Document at www.mesaaz.gov/benefits.

Note: All City of Mesa Prescription Drug Plans are considered Creditable with Medicare Part D. The Notice of Creditable Coverage is on mesaaz.gov/benefits and at the end of this Workbook

PRESCRIPTION BENEFIT 2013				
Choice and Choice Plus Plans	**Annual Deductible per Person**	**Generic**	**Formulary Brand****	**Non-Formulary Brand****
RETAIL – Up to 30-day Supply (at any in-network pharmacy)				
Member Pays	$50.00*	20%	25%	40%
Minimum Copay per Rx		$5	$30	$50
Maximum Copays per Rx		$50	$100	$150
*Deductible waived on Generic - only applies to Formulary Brand and Non-Formulary Brand drugs				
MAIL ORDER – Up to 90-Day Supply (at Mail Order Pharmacy or Retail CVS Caremark pharmacies)				
Member Pays	$ 0.00	20%	25%	40%
Minimum Copay per Rx		$12.50	$75	$125
Maximum Copays per Rx		$100	$200	$300
** Medications with no Generic alternative are covered as Formulary or Non-Formulary Brand				

Copay Choice Plan	Generic	Formulary Brand**	Non-Formulary Brand**
RETAIL – Up to 30-day Supply (at any in-network pharmacy)			
Member Pays	$10	$40	$75
MAIL ORDER – Up to 90-Day Supply (at Mail Order Pharmacy or Retail CVS Caremark pharmacies)			
Member Pays	$20	$80	$150
** Medications with no Generic alternative are covered as Formulary or Non-Formulary Brand			

Basic Choice Plan	Annual Total Deductible per Person (mail & retail combined)	Generic	Formulary Brand**	Non-Formulary Brand**
RETAIL – Up to 30-day Supply (at any in-network pharmacy)				
Member Pays	$250.00	20%	25%	40%
Minimum Copay per Rx		$5	**$30**	**$50**
Maximum Copays per Rx		$50	$100	$200
MAIL ORDER – Up to 90-Day Supply (at Mail Order Pharmacy or Retail CVS Caremark pharmacies)				
Member Pays	$250.00	20%	25%	40%
Minimum Copay per Rx		$10	$50	$80
Maximum Copays per Rx		$100	$200	$300
** Medications with no Generic alternative are covered as Formulary or Non-Formulary Brand				

Dental Plan 2013

City of Mesa Dental Plans are self-insured and self-administered. You may choose any dental care provider. There are no in-network or out-of-network provisions under these plans. Claims are processed by the City of Mesa Benefits Office.

You have three plan designs from which to choose, based upon individual and family needs:

- **Preventative Choice Plan** –Preventative services and basic restorative care to $500 annually.
- **Dental Choice Plan** – Preventative, basic, and major restorative coverage to $1,200 annually.
- **Dental Choice Plus Plan** – Coverage to $1,500/year; orthodontia for children under age 19.

DENTAL PLAN HIGHLIGHTS 2013			
DENTAL SERVICES	**PREVENTATIVE CHOICE PLAN**	**DENTAL CHOICE PLAN**	**DENTAL CHOICE PLUS PLAN**
Deductible per calendar year	$100/person; $300/family Restorative care only	$100/person;$300/family Restorative care only	$100/person; $300/family Restorative care only
Preventative visits Include exam, tooth cleaning, periodic x-rays (excludes periodontal services)	Not subject to deductible 100%	Not subject to deductible 100%	Not subject to deductible 100%
Basic Restorative, sealants (under age 19) fluoride, fillings, extractions	After deductible, 80%	After deductible, 80%	After deductible, 80%
Major Restorative (crowns, bridges, root canals, dentures, oral surgery, periodontal, & endodontic)	Not Covered	After deductible, 80%	After deductible, 80%
Orthodontia coverage applies only to dependent children under age 19	Not Covered	Not Covered	No Deductible, 80% Coverage, $1,200 per year $2,400 Lifetime Max
Annual Maximum Payable	$500 per person	$1,200 per person	$1,500 per person
This chart is a summary of how eligible services will be covered. For a complete list of services and more detailed information, please refer to the City of Mesa Health Plan Document available at www.mesaaz.gov/benefits or from Employee Benefits.			

Non-Covered Dental Services
As with the Medical plans, there are certain services that are not covered under any of the Dental plans including:

- Expenses exceeding the Allowed amount (see below).
- Orthodontia for children under age 19 that started ***before*** benefits began with the City of Mesa.
- Analgesia, sedation, hypnosis, nitrous oxide and/or related services provided for apprehension or anxiety, except when medically necessary.
- General anesthesia, except for impacted teeth or as necessary for teeth covered partially or totally by bone, root canal treatment or gingivectomy.
- Cosmetic services, including but not limited to veneers and facings.
- Drugs and medicines (these may be covered under the prescription plan).
- Dental implants.
- Athletic mouth guards.

For more information about these and other services that are not covered, please refer to the Plan Document or contact Employee Benefits at (480) 644-2299.

Allowed Charges

ALL dental claims that are submitted to the Benefits Office are compared to a schedule of allowed charges before they are processed.

- When the billed charge for services is higher than the amount allowed for the provider's location (by zip code), benefits will be paid based on the allowed amount.
- The member is responsible for paying the difference between the billed charge and the allowed amount.
- To avoid paying more than the allowed charges for dental services, members should have providers submit a Predetermination of Dental Benefits form to the Employee Benefits Office **BEFORE** services are rendered
  - The Benefits Office will indicate any costs over the allowed charges.
  - Deductibles and coinsurance will be determined based upon the provider's estimate of costs.

Vision Plan 2013

Vision care benefits are provided by Vision Service Plan (VSP). The City offers its members two types of plans:

- **Basic Vision** – Offers basic coverage at a nominal cost.
- **Vision Plus** – Offers additional coverage for a higher monthly premium.

Select a Participating Provider at www.vsp.com or call 1-800-877-7195.

VSP IN-NETWORK PLAN HIGHLIGHTS		
	BASIC VISION PLAN 12/24/24	**VISION PLUS PLAN 12/12/12**
Comprehensive Vision Exam	$10 copay, once every 12 months	$10 copay, once every 12 months
Materials	$10 copay, once every 24 months	$10 copay, once every 12 months
The materials copay is a single payment that applies to the entire purchase of eyeglasses (lenses and frames), or contacts in lieu of eyeglasses.		
Pair of Lenses for Eyeglasses • Standard single vision • Standard lined bifocal • Standard lined trifocal	Once every 24 months Covered in Full Covered in Full Covered in Full	Once every 12 months Covered in Full Covered in Full Covered in Full
Lens Options • Standard Scratch Coating • Tints • Polycarbonate Lenses* • UV Coating • Basic Progressive Lenses *Covered in Full for Children under 18	 Available at a discount Available at a discount Available at a discount Available at a discount Available at a discount	 Available at a discount Available at a discount Available at a discount Available at a discount Available at a discount
Lens options not covered by the plan may be available at a discount		
Eyeglass Frames	Once every 24 months receive a $130 retail frame allowance PLUS 20% discount off amounts over the retail allowance.	Once every 12 months receive a $130 retail frame allowance PLUS 20% discount off amounts over the retail allowance.
Contact Lenses in lieu of Eyeglasses (Lenses & Frames)	Once every 24 months	Once every 12 months
Covered in full elective contact lenses • $200 Allowance in lieu of lenses and frames • Member receives 15% discount off doctor's professional fees for Contact Lens fitting and evaluation	$200 allowance once every 24 months. Fitting/evaluation is offered at a 15% discount. If a member chooses a contact lens not currently part of the Contact Lens Care Program, they have the flexibility to use their elective contact lens allowance any way they choose. The allowance can go toward contact lens services and contact lenses. Members will always receive 15% off all contact lens services from their VSP doctor. VSP covered contact lenses may vary by provider.	$200 allowance once every 12 months. Fitting/evaluation is offered at a 15% discount. If a member chooses a contact lens not currently part of the Contact Lens Care Program, they have the flexibility to use their elective contact lens allowance any way they choose. The allowance can go toward contact lens services and contact lenses. Members will always receive 15% off all contact lens services from their VSP doctor. VSP covered contact lenses may vary by provider.
Medically Necessary Contacts Lenses • $250 Allowance	Applies to individuals who cannot wear eyeglasses because of a medical condition, allergy, etc. Covered once every 24 months	Applies to individuals who cannot wear eyeglasses because of a medical condition, allergy, etc. Covered once every 12 months
Refractive Eye Surgery- Member may receive approximately 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities. Many other services are available at discounted rates. Check with your vision care provider or the Vision Service Plan website at www.vsp.com.		

VSP OUT-OF-NETWORK PLAN HIGHLIGHTS

SERVICE	AMOUNT
Exam	
• Optometrist	Up to $45
• Ophthalmologist	Up to $45
Contact Lenses (in lieu of eyeglasses)	
• Elective	Up to $200
• Necessary	Up to $250

SERVICE	AMOUNT
Lenses	
• Single Vision	Up to $40
• Bifocal	Up to $60
• Trifocal	Up to $80
• Lenticular	Up to $100
Frames	Up to $70

TO FILE AN OUT OF NETWORK CLAIM:
Submit an itemized receipt with the covered member's ID number, name, address, phone number, patient's date of birth and relationship to member to the following address:

VSP
Attn: Out-of-Network Claims
PO Box 997105
Sacramento, CA 95899-7105

Be sure to write on your receipt "City of Mesa Vision Plan"

Limitations and Exclusions
This plan is designed to cover eye examinations and corrective eyewear. Benefits are payable only for expenses incurred while the group and individual member's coverage is in force.

The following services and materials are not covered under the Vision Service Plan
- Orthoptics or vision training and any associated supplemental testing
- Plano lenses (i.e. refractive error less than +/- 0.50 diopter power)
- Two pairs of glasses instead of bifocals
- Medical or surgical treatment of the eyes
- Replacement of lenses and frames furnished under this program, except at the normal intervals when services are available

The following items are not covered under the VSP Plan contact lens coverage
- Corneal Refractive Therapy (CRT) or Orthokeratology
- Replacement of lost or damaged lenses
- Insurance policies or service agreements
- Plano lenses (i.e. refractive error less than +/- 0.50 diopter power)
- Artistically painted lenses
- Additional office visits associated with contact lens pathology
- Contact lens modification, polishing or cleaning

Choosing the Best Plan for You and Your Family

How do I know which plan to choose?

Although the City of Mesa Benefits Office cannot recommend a specific plan, this section includes some information for you to consider as you make your health insurance plan decisions.

Member premium costs

- Which of the plans will fit best within your family's budget?
    - Do you have the immediate financial resources to handle the deductible?
- Keep in mind that health insurance premiums are deducted on a pre-tax basis
    - The premium does not equal a reduction in your take home pay

Health care expense history

- What was your out of pocket expense during the last calendar year?
- How much are you actually USING your benefits?
- How much do you think you will use them in the future?
- What is your network utilization like? Does it have to be that way?

Do the math!

- Add how much you pay in premiums
- Add how much you pay for medical out of pocket expenses
- Add how much you pay for prescription medication out of pocket expenses
- Add naturopath or homeopath expenses

Compare

- How much are you paying under your current plan?
- How much would you paying under the other current plans?

Consider

- Are you enrolled in the most expensive plan just because it's convenient or because it gives you a feeling of security?
- How likely are you to spend more than the out-of-pocket or annual maximums?
- Are you or one of your family members quite ill with a chronic condition?
- Have you, or has someone in your family made numerous visits to the hospital?
- Are you, or is someone in your family, likely to need surgery, or perhaps a crown or root canal, in the coming year?
- Is one of the children going to need of braces for their teeth?
- Do you want to change vision plans so that you can have more or less frequent benefits?

Use Available Resources

- Review Explanation of Benefits forms that are sent every time a claim is processed
- Look up your claims online at www.mesaaz.gov/benefits
- Pharmacy receipts from both Retail and Mail Order pharmacies

Getting the Best Bang for Your Health Care Buck

How to Maximize Your Benefits and Save Money for Yourself and the Employee Benefits Trust

Choose In-Network PPO providers

- Make sure **ALL** providers involved in your care are in the Blue Cross Blue Shield of Arizona PPO network if you live in Arizona.
- If you live outside of Arizona, enroll in the out-of-state BCBS network and use the in-network providers in that network.
- Ensure that **ALL** providers involved (such as the surgeon, anesthesiologist, assistant surgeons, and the healthcare facility) are in-network providers.

Use the Prescription Plan Wisely

- Choose Generic medications whenever possible. Not only will you get a better benefit, but it will also help keep premiums down by being less expensive for the Employee Benefit Trust.
- Take advantage of any retail pharmacy chain $4/$10 Generics program.
- Go to 90-supply purchasing for the medications you take regularly – either through the Mail Order pharmacy or using CVS Caremark Retail pharmacies at mail order prices. Both you and the Trust receive a greater discount on each drug when purchased in 90-day supply quantities.
- The dispensing fee is also less at mail order (up to 90-day supply) pricing than it is at retail pricing.
- Ask your doctor about possible alternatives to more expensive Brand Name medications, especially non-Formulary Brand Name medications.
- Do cost comparisons. If there is a less expensive medication that could give you the same results, try it.

Out-of-Network Coverage

The Medical Plan offers out-of-network coverage for those members who choose to use a provider who is not in the Blue Cross Blue Shield of Arizona network. However, in every plan, out of pocket costs for using non-network providers are substantially more for the member and for the Employee Benefit Trust.

In addition, there are other increased costs for using out-of-network providers:

- **No Out-of-Pocket Maximum** - members who choose out-of-network providers will pay ***all*** deductibles and ***all*** coinsurances, regardless of total cost.
- **Coinsurance will be calculated based on allowable costs** for the out-of-network service.
- Members will pay any costs billed by out-of-network providers above the allowable cost in addition to their coinsurance.
- **Out-of-network emergency room visits** will not be paid in-network if not a true life threatening emergency and medically necessary.
- **Any out-of-network post-emergency follow up care will be covered at out-of-network rates.**
- **Out-of-network services will not be paid at the in-network rate** unless the City's independent medical review has determined that there is not an appropriate provider in the network, based on medical necessity.

Coverage for Emergency Services Outside Network Area

All plans provide coverage for emergency services incurred while traveling outside the network area. Emergency services will be covered when that level of care is required due to medical necessity.

- The initial medically necessary emergency visit will be covered under in-network co-insurance.
- All follow-up visits and services must be provided by an in-network provider.

Important Phone Numbers and Websites

Contact	Website / Telephone	Description
Arizona Foundation for Medical Care	www.azfmc.com (602) 252-4042	Precertification, case management, medical review
Blue Cross Blue Shield of Arizona	www.azblue.com	Find an in-network medical provider in **Arizona**.
Blue Cross Blue Shield Nurse Line	(866) 422-2729	Call a Blue Cross Blue Shield professional nurse, 24 hours a day, 7 days a week
CVS Caremark	www.caremark.com (855) 264-5048 beginning 1/1/2013	Find in-network pharmacies and get information about copays, coinsurance and Formularies.
VSP	www.vsp.com (800) 877-7195	Find a Vision Service Plan provider and other coverage information.
Employee Benefits	(480) 644-2299 www.mesaaz.gov/benefits	View the City of Mesa Plan Document, get benefit forms, and your benefit information and claim history. Eligibility and Benefits Verification.
Blue Cross Blue Shield Out-of-State Network	(866) 288-5788	For members enrolled in the Blue Cross Blue Shield Out-of-State Network. To enroll in the Out-of-State plan contact Employee Benefits.

Required Notices

Annual Notification - Women's Health and Cancer Rights Act of 1998

Federal law requires the following notification: Group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive breast surgery. This Plan complies with the Women's Health and Cancer Rights Act (WHCRA) that indicates that for any covered individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage will be provided in a manner determined in consultation with the attending physician and the patient, including:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and physical complications for all stages of mastectomy, including lymphedemas.

Coverage is subject to the Plan's normal rules, including in-network co-payments or out-of-network annual deductibles and coinsurance provisions. If you have any questions about this law, including Plan benefits for mastectomies or reconstructive surgery, please contact, Employee Benefits Administrator at (480) 644-4421.

HIPAA – Health Insurance Portability and Accountability Act of 1996

Effective April 14, 2003, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a federal law, requires that health plans like the City of Mesa Health Plan (hereafter referred to as the "Plan"), maintain the privacy of your personally identifiable health information (called Protected Health Information or PHI).

- The term "Protected Health Information" (PHI) includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.
- PHI does not include health information contained in employment records held by the City of Mesa in its role as an employer, including but not limited to health information related to disability, work-related illness/injury, sick leave, Family or Medical leave (FMLA), life insurance, dependent care FSA, drug testing, etc.
- A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which was previously distributed to you or distributed to you upon enrollment in the Plan and is also available from the Employee Benefits Office or at www.mesaaz.gov/benefits.

Medicaid & the Children's Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. **If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of September 1, 2010. You should contact your State for further information on eligibility.**

ALABAMA – Medicaid	**CALIFORNIA** – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-800-362-1504	Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-866-298-8443
ALASKA – Medicaid	**COLORADO** – Medicaid and CHIP
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Medicaid Website: http://www.colorado.gov/ Medicaid Phone: 1-800-866-3513 CHIP Website: http:// www.CHPplus.org CHIP Phone: 303-866-3243
ARIZONA – CHIP	
Website: http://www.azahcccs.gov/applicants/default.aspx Phone: 1-877-764-5437	
ARKANSAS – CHIP	**FLORIDA** – Medicaid
Website: http://www.arkidsfirst.com/ Phone: 1-888-474-8275	Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml Phone: 1-866-762-2237
GEORGIA – Medicaid	**MONTANA** – Medicaid
Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Telephone: 1-800-694-3084
IDAHO – Medicaid and CHIP	**NEBRASKA** – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092
INDIANA – Medicaid	**NEVADA** – Medicaid and CHIP
Website: http://www.in.gov/fssa/2408.htm Phone: 1-877-438-4479	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900 CHIP Website: http://www.nevadacheckup.nv.org/ CHIP Phone: 1-877-543-7669
IOWA – Medicaid	
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	
KANSAS – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: https://www.khpa.ks.gov Phone: 800-766-9012	Website: http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm Phone: 1-800-852-3345 x 5254
KENTUCKY – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-342-6207	
MAINE – Medicaid	**NEW MEXICO –** Medicaid and CHIP

Website: http://www.maine.gov/dhhs/oms/ Phone: 1-800-321-5557	Medicaid Website: http://www.hsd.state.nm.us/mad/index.html Medicaid Phone: 1-888-997-2583 CHIP Website: http://www.hsd.state.nm.us/mad/index.html Click on Insure New Mexico CHIP Phone: 1-888-997-2583
MASSACHUSETTS – Medicaid and CHIP	
Medicaid & CHIP Website: http://www.mass.gov/MassHealth Medicaid & CHIP Phone: 1-800-462-1120	
MINNESOTA – Medicaid	**NEW YORK –** Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone (Outside of Twin City area): 800-657-3739 Phone (Twin City area): 651-431-2670	Website: http://www.nyhealth.gov/health_care/ medicaid/ Phone: 1-800-541-2831
MISSOURI – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dss.mo.gov/mhd/index.htm Phone: 573-751-6944	Website: http://www.nc.gov Phone: 919-855-4100
NORTH DAKOTA – Medicaid	**UTAH** – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid / Phone: 1-800-755-2604	Website: http://health.utah.gov/medicaid/ Phone: 1-866-435-7414
OKLAHOMA – Medicaid	**VERMONT**– Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://ovha.vermont.gov/ Telephone: 1-800-250-8427
OREGON – Medicaid and CHIP	**VIRGINIA** – Medicaid and CHIP
Medicaid & CHIP Website: http://www.oregonhealthykids.gov Medicaid & CHIP Phone: 1-877-314-5678	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
PENNSYLVANIA – Medicaid	**WASHINGTON** – Medicaid
Website: http://www.dpw.state.pa.us/partnersproviders/medical assista nce/doingbusiness/003670053.htm Phone: 1-800-644-7730	Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-877-543-7669
RHODE ISLAND – Medicaid	**WEST VIRGINIA** – Medicaid
Website: www.dhs.ri.gov Phone: 401-462-5300	Website: http://www.wvrecovery.com/hipp.htm Phone: 304-342-1604
SOUTH CAROLINA – Medicaid	**WISCONSIN** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493 Phone: 1-800-440-0493	Website: http://www.health.wyo.gov/healthcarefin/index.html Telephone: 307-777-7531

To see if any more States have added a premium assistance program since September 1, 2010, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration

www.dol.gov/ebsa

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services

www.cms.hhs.gov

1-866-444-EBSA (3272) 1-877-267-2323, Ext. 6156

Medicare Mandatory Reporting Requirement

As a health plan payor, the City of Mesa is required to comply with a number of federal laws, including HIPAA (see above) and the Medicare Mandatory Reporting Requirement. This requirement came about because of increased misunderstandings by providers and Medicare recipients regarding the primary/secondary relationship between Medicare and their other Group Health Plan (like the plans offered by the City of Mesa).

When a person becomes eligible for Medicare, either because they have reached their Medicare-eligibility age OR they have been disabled in accordance with Medicare rules, they are automatically enrolled in Medicare Part A, which covers the person under Medicare for Hospitalizations. They will also have the option of enrolling in Medicare Part B (for professional services, such as doctor visits, lab and x-ray services), for which there is a monthly premium. When a person is also covered by another insurance plan, such as those offered by the City of Mesa, both the City and Medicare must determine which plan is primary (i.e. which plan pays first when services are rendered) and which plan is secondary.

Many people assume that when they become eligible for Medicare that Medicare is automatically primary. This is not necessarily the case, especially if the person is still an active employee or is the spouse of an active employee enrolled in a group health plan. For this reason, the Centers for Medicare and Medicaid Services (CMS) has enacted the Medicare Mandatory Reporting Requirement — to ensure those who are enrolled in both Medicare and another group health plan understand which plan is considered their primary insurance.

To facilitate this process, CMS is requiring all health insurance payors to submit the names and social security numbers of all of their members, regardless of their age or Medicare status. They will then verify which people are enrolled in Medicare and will communicate this information to the Employee Benefits Office, so we can notify the member which insurance coverage should be considered primary. As a result of this requirement, we are required to have all plan members (employees and retirees) provide us with the social security numbers of their dependents (spouses and children). We will then communicate this information to CMS as required by federal law.

Please note this information will be kept completely confidential and private, as the City of Mesa Employee Benefits Office is bound by HIPAA to maintain the privacy of all personal health information. If you have any questions or concerns about this new requirement, please contact Employee Benefits at (480) 644-2299.

Important Notice from the City of Mesa About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the City of Mesa and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The City of Mesa has determined that the prescription drug coverage offered by the City of Mesa Medical Plan, including the Basic Choice PPO, Choice PPO, Choice Plus PPO, and Choice Copay plans, is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current City of Mesa coverage will not be affected. Under the prescription drug coverage plan provisions under the City of Mesa Choice Medical Plan that Medicare eligible individuals have available to them when they become eligible for Medicare Part D, they can keep this coverage if they elect part D but this plan will not coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current City coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the City of Mesa and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information or call the City of Mesa Benefits Office at 480-644-2299.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the City of Mesa changes. You also may request a copy of this notice at any time,

Contact:

City of Mesa
Employee Benefits Administrator
P.O. Box 1466
Mesa, AZ 85211-1466

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:
Visit www.medicare.gov
Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).